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Navigating Work Stress: A Qualitative Descriptive Exploratory Study of Health Care Aides' Experiences in Assisted Living Facilities

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Abstract

Introduction: Health care aides (HCAs) provide the majority of direct, hands-on care to residents in assisted living facilities (ALFs), yet the specific work-related stress experienced by this workforce remains poorly characterized in the Canadian literature. This study aimed to explore how HCAs working in ALFs experience, interpret, and manage work-related stress.

Methods: A descriptive exploratory qualitative design was used. Fourteen HCAs employed across three ALFs operated by a not-for-profit organization in two Southern Alberta communities were recruited through purposive sampling supplemented by snowball referral. Semi-structured, face-to-face interviews were conducted by the researcher, audio-recorded, transcribed verbatim, and analyzed using reflexive thematic analysis, informed by the transactional model of stress and coping and the job demands-resources model.

Results: Four interconnected themes were generated: understanding and experiencing work stress; the genesis of work stress; consequences of work stress on HCAs' lives; and navigating and coping with work stress. Organizational factors, workload, staffing shortages, leadership, and workplace relationships, emerged as the most frequently described sources of stress, alongside resident- and family-related stressors, including workplace violence. Coping strategies ranged from social support and self-care to maladaptive behaviors such as substance use and absenteeism. Participants described an ideal workplace as one characterized by approachable and appreciative leadership, adequate staffing, dedicated physical space for staff, and regular opportunities for communication with management.

Conclusion: This study offers valuable insights into how HCAs perceive and cope with work stress in ALFs. By specifically focusing on this underexamined group the findings contribute a distinctive perspective to existing literature. Employers and service providers can utilize these insights to recognize and address stressors, thereby improving working conditions and the overall

well-being of HCAs. This improvement, in turn, positively impacts the quality of care provided to ALF residents. Further research is recommended to delve deeper into the unique experiences of work stress among HCAs and their coping mechanisms.
Keywords: Assisted living facilities; Health care aides; Occupational stress; Coping; Qualitative research; Thematic analysis

Introduction

The global population is aging at an unprecedented rate, and the demand for long-term and residential care services continues to rise accordingly.[1] In Canada, the responsibility for delivering direct, hands-on care to older adults in residential and assisted living settings depends substantially on health care aides (HCAs), an occupational group that performs the majority of activities-of-daily-living support in these environments.[2]

HCAs are estimated to constitute more than 70% of the direct-care workforce in the continuing care sector and to deliver 80% to 90% of hands-on resident care, yet their working conditions and occupational stress remain comparatively understudied relative to regulated nursing and allied health professions.[2]

In Alberta, the scale of this workforce challenge has prompted renewed provincial attention. The Government of Alberta's 2023 health workforce strategy, which committed an additional $158 million toward recruitment, retention, and workforce planning across the health sector, explicitly identifies frontline continuing-care staff, including HCAs, as a priority population for retention and support, underscoring the practical relevance of understanding the sources of work-related stress in this group.[3, 4]

Population aging in Alberta is occurring faster than in most other Canadian provinces, driven by increasing life expectancy and an expanding proportion of residents over the age of 65.[5] The World Health Organization projects that the global population aged 60 years and older will nearly double between 2015 and 2050, intensifying demand for residential and assisted living care internationally.[1] Statistics Canada projections similarly indicate sustained growth in the population of adults aged 75 and older through 2036, with corresponding growth in demand for continuing-care services.[6] This demographic trajectory places increasing pressure on the direct-care workforce, including family caregivers and paid care providers such as HCAs, who together shoulder the practical burden of supporting older adults with complex care needs, needs that are further compounded by the clinical complexity of treating older patients in everyday practice.[7 8]

Assisted living facilities (ALFs) provide residential accommodation combined with personal care and support services for older adults who require assistance with daily activities but do not require the intensity of care provided in a nursing home.[9] HCAs working in this setting are responsible for a broad scope of hands-on tasks, including bathing, dressing, mobility assistance, feeding, and emotional support, often with less clinical backup than is available in acute or long-term care settings.

While occupational stress among nurses and other regulated health professionals has been extensively documented, considerably less is known about how HCAs, who typically have less formal training, lower wages, and less professional recognition than regulated staff, experience

and interpret work-related stress specifically within the ALF context, where staffing models, supervisory structures, and resident acuity differ meaningfully from long-term care or hospital settings. Specifically, it remains unclear which stressors are most salient to HCAs in the ALF setting, as distinct from long-term care or hospital settings, and how HCAs themselves characterize and cope with these stressors in their own words, the knowledge gaps this study addresses.

Prior Canadian research has examined missed and rushed care among HCAs in nursing homes,[10] and burnout more broadly across the nursing home HCA workforce,[11] but comparatively few studies have focused specifically on the ALF context or have elicited HCAs' own descriptions of stress in their own words. This gap suggests, rather than establishes, that the sources and lived experience of work stress in ALFs may differ in emphasis from those already reported in nursing home settings.

The World Health Organization recognizes psychosocial risks and work-related stress as a significant threat to worker mental health worldwide, noting that poor working environments, including excessive workloads, low job control, and job insecurity, can adversely affect mental health.[12] Direct-care workers such as HCAs, whose work combines physical labour, emotional demands, and limited decision-making authority, may be particularly exposed to these psychosocial risks.

The aim of this study was to explore how HCAs working in assisted living facilities in Southern Alberta experience, interpret, and manage work-related stress, including its perceived sources, consequences, and coping strategies.

Materials and Methods

Study Design

A descriptive exploratory qualitative design was used to describe, understand, and explore HCAs' experience of work-related stress in ALFs, consistent with Sandelowski's account of qualitative description as an approach suited to producing a comprehensive, data-near summary of a phenomenon in the words of those who experience it, and with established principles of rigor in nursing research more broadly.[13 14]

The study was conducted across three ALFs operated by a Christian, hospital-based not-for-profit organization in two communities in Southern Alberta, Canada.

This manuscript reports data originally collected for the author's master's thesis research.[15] A related, shorter report drawing on an overview of this same interview dataset was previously published as a brief research communication.[16] The present manuscript reports a substantially expanded and independently structured analysis of the full dataset, including an explicit dual theoretical framework (the transactional model of stress and coping and the job demands-resources model), COREQ-consistent methodological reporting,[17] a verbatim-quotation-based thematic structure organized by theme and subtheme, and a theory-integrated discussion; none of these elements were part of the earlier, more limited report.

Sampling and Recruitment

Participants were recruited using purposive sampling: recruitment posters were placed at all three facilities, with a target of four to five participants per facility. After six weeks, only nine HCAs had volunteered. With approval from the Human Subject Research Committee (HSRC), recruitment was expanded through a second poster, snowball referral from existing participants, and direct approach by the researcher at nursing stations; this expanded strategy yielded five additional participants, for a total sample of 14 HCAs. Eligible participants were currently employed as an HCA providing direct resident care, had been employed at their facility for at least 12 months, self-identified as having experienced work-related stress in their role (assessed through a screening question during initial contact), and were able to communicate in English. Participants on extended leave, in purely administrative roles, or employed on an agency/casual basis with less than 12 months of tenure were excluded. The English-language criterion may limit the transferability of findings to HCAs who are not proficient in English, a limitation addressed further below.

Data Collection

All interviews were conducted personally by the researcher (M.A.), who at the time of data collection was a graduate nursing student with prior clinical experience working as an HCA. The researcher had no prior supervisory or employment relationship with any participant and had received training in qualitative interviewing through graduate coursework. A reflexive journal was maintained throughout data collection and analysis to document the researcher's own assumptions, reactions, and potential sources of bias arising from this shared occupational background.

Data were collected using a semi-structured interview guide developed from the relevant literature and the researcher's clinical experience as a former HCA. The guide was refined after two pilot interviews, which were retained in the final analysis (contributing to the total sample of 14). The interview guide is available as supplementary material upon request.

Interviews lasted between 30 and 65 minutes (mean approximately 45 minutes); four interviews exceeded 60 minutes. All interviews were audio-recorded and transcribed verbatim.

Data collection continued until thematic saturation was judged to have been reached, operationalized as the point at which no new themes or subthemes emerged from successive transcripts. Saturation was first judged by the researcher after the 12th interview and was confirmed through two additional interviews (interviews 13 and 14), which introduced no new thematic content.

Data Analysis

Transcripts were analyzed using reflexive thematic analysis following the six recursive phases described by Braun and Clarke: familiarization with the data, generation of initial codes, construction of candidate themes, review and refinement of themes, definition and naming of final themes, and production of the written report.[18 19] Coding combined an inductive approach during initial familiarization and code generation with a deductive, theory-informed approach during

theme development and interpretation, drawing on the transactional model of stress and coping[21] and the job demands-resources model[20-22] (described further below).

Theoretical Framework

Two complementary theoretical frameworks informed the interpretation of participants' accounts. The transactional model of stress and coping (TMSC) conceptualizes stress as arising from an individual's cognitive appraisal of a situation as taxing or exceeding their resources, followed by efforts to cope with that appraisal.[23 24] This framework guided the interpretation of how HCAs evaluated (appraised) workplace demands and selected coping responses. The job demands-resources (JD-R) model complements this individual-level lens by distinguishing between job demands (aspects of work requiring sustained physical or psychological effort, such as workload and resident violence) and job resources (aspects of work that help achieve goals or reduce demands, such as supervisory support and training), proposing that excessive demands relative to available resources produce strain.[20-22] Both frameworks were applied deductively during the later stages of analysis, after inductive open coding had generated the initial thematic structure, to interpret why particular workplace features were experienced as stressful and how coping responses related to the balance of demands and resources.

Trustworthiness

Trustworthiness was addressed using Lincoln and Guba's four criteria.[25 26] Credibility was supported through member checking: interview summaries were shared with all 14 participants, of whom nine responded to confirm the accuracy of the summaries; no participant requested changes. Dependability was supported through an audit trail of coding decisions and reflexive analytic memos. Confirmability was supported through ongoing reflexive journaling addressing the researcher's own former HCA background and its potential influence on data collection and interpretation. Transferability was supported through thick description of the study setting, participants, and findings. As a limitation of trustworthiness, analysis was conducted by a single researcher without an independent second coder or investigator triangulation, which is addressed further in the Limitations section.

Ethical Considerations

This study received ethics approval from the Human Subject Research Committee (HSRC) of the University of Lethbridge (Internal File 2013-074; approved November 12, 2013 to August 30, 2014), consistent with the Tri-Council Policy Statement, Alberta's Health Information Act, and university policy. Site-level ethics approval was also obtained from each participating facility. All participants provided written informed consent prior to their interview. Participation was voluntary, and participants were informed of their right to withdraw at any time without consequence. Audio recordings were destroyed following transcription, pseudonyms were used throughout data analysis and reporting, and consent forms were stored separately from de-identified study data.

Contextual Note on Staffing Ratios

Approximate staff-to-resident ratios reported in this manuscript were not collected systematically through a structured interview question or demographic form; rather, they reflect the researcher's direct observation across the three participating facilities during the data-collection period. They are presented here as contextual background information only, and not as empirical study data, and this distinction is noted as a limitation of the study.

Results

Participant Characteristics

Fourteen HCAs participated in this study (12 female, 2 male). Female participants ranged in age from 20 to 49 years (mean 33 years) and male participants ranged from 36 to 38 years (mean 37 years). Participants had between 2 and 17 years of accumulated HCA experience. Ten participants held a Canadian HCA certificate (eight from Alberta, one from Ontario, one from Saskatchewan), two were nursing students, and two had received nursing education and experience outside Canada. Full demographic detail is presented in Table 1. Participants' years of accumulated experience and certification pathway are reported here descriptively only; how professional experience may relate to participants' approaches to managing work stress is addressed as an interpretive point in the Discussion. Similarly, the geographic distribution of participants' HCA certification (Table 1) is reported descriptively here; possible links between certification jurisdiction and regional training or care standards are considered, with appropriate caution, in the Discussion.

Table 1. Participant characteristics (N= 14)

Category/ Subcategory	N (%)
Age (years)	
20–29	6(43)
30–39	4(29)
40–49	4(29)
Gender	
Female	12(86)
Male	2(14)
Experience (years)	
1–5	8(57)
6–10	3(21)
11–15	1(7)
>15	2(14)
Education	
HCA certificate (Canada)	10(71)
LPN/RN student	2(14)
RN trained outside Canada	2(14)
Employment status	
Full-time	3(21)
Part-time	8(57)
Casual	3(21)
First language	
English	12(86)
Other	2(14)

Two participants, for whom English was not a first language, described additional difficulty articulating their experience of work-related stress during the interview, a point that is revisited as a transferability consideration in the Limitations section. When asked to rate their perceived work-related stress on a scale of 1 to 10, participants' self-ratings ranged from 6 to 10, indicating uniformly high perceived stress across the sample.

Table 2. Observed staff-to-resident ratios (contextual, not systematically collected)

Unit	Shift	Approximate ratio (staff: residents)
Regular floor	Morning	1:8
Regular floor	Evening	1:17
Secure dementia-care cottage	Morning	1:6
Secure dementia-care cottage	Night	1:12

Thematic Findings

Four interconnected themes, each comprising two to five subthemes, were generated through reflexive thematic analysis of the 14 interview transcripts. The full thematic structure, presented as a coding table rather than a figure to preserve the level of subtheme detail, is summarized in Table 3: (1) understanding and experiencing work stress; (2) the genesis of work stress; (3) consequences of work stress on HCAs' lives; and (4) navigating and coping with work stress.

Theme 1: Understanding and Experiencing Work Stress

This theme captures how participants defined and physically or emotionally recognized work-related stress in themselves and comprised two subthemes: physical and emotional manifestations of stress, and ambivalence toward job satisfaction.

Participants described recognizing stress through bodily sensations as much as through thoughts or emotions. Representative verbatim quotations are presented throughout this section, attributed to anonymized participant identifiers (pseudonym, role, and employment status, e.g., "Sue, HCA, part-time") rather than real names, consistent with the confidentiality protections described in the Methods.

> *I can tell physically, physiologically, my shoulders tense up, and I breathe really heavy, and I'm just constantly looking everywhere…and at that point usually mistakes end up being made.*
>
> *— Sue, HCA, part-time*

> *I get anxious, and I'm a very emotional person…so for me, my anxiety is heightened because of stress that other people are putting on, or just the job itself is putting on.*
>
> *— Mary, HCA*

Despite describing considerable stress, most participants remained satisfied with their work overall, while a smaller group expressed clear dissatisfaction, reflecting an ambivalent relationship between stress and satisfaction.

> *I find it rewarding; I think it's a really good job…but at the same time, it's very challenging physically and mentally.*
>
> *— Kat, HCA*

> *I'm not satisfied at all…working for the staff you work with is very frustrating at times, and you really have no say as a health care aide.*
>
> *— Joyce, HCA*

Theme 2: Genesis of Work Stress

This theme describes the perceived sources of work-related stress and comprised two explicitly defined categories: (1) stressors related to the behaviours, attitudes, and situations of residents, families, leadership, and co-workers; and (2) stressors related to the challenging structural work environment. Corresponding subthemes are presented in Table 3.

Resident- and family-related stressors were described by the majority of participants, including behavioural, verbal, and, less frequently, physical and sexual aggression, which participants generally attributed to disease progression rather than deliberate intent.

> *Some residents are really abusive…I tried to move her, and she would slap at me and hit me and start yelling, then it affected all the other residents…it became extremely stressful.*
>
> *— Linda, HCA*

Leadership and organizational stressors, including perceived lack of appreciation, unapproachable management, and inconsistent supervisory support, were reported by nearly all participants.

You do such a good job, and you work your butt off, and they don't even show recognition for it…you are making your management look good, and while you are doing so well, somebody else is doing so crappy, and yet you are getting blamed for it too.

— Joe, HCA

I am so scared of management…every time I see the site manager's name beside my name, I start sweating…I have no clue why I'm scared from management.

— Alayna, HCA

Co-worker relationships, particularly with inexperienced or unreliable casual staff, were identified as a distinct source of stress separate from leadership and resident-related stressors.

Being casual can be so difficult…when people don't document things that are pertinent to that particular resident…I make mistakes, I don't do things the way they would like me to, and then I come back the next day and I get chewed out.

— Sue, HCA, describing the casual role

Workload and staffing pressures, including working short-staffed and performing tasks beyond the formal job description, were described as a persistent and structural source of stress rather than an occasional occurrence.

I remembered one day…one of the workers called in, and they did not cover his shift, so we stayed three from 3 till 7…just imagine three staff doing the job of five.

— Mark, HCA

Two male participants described gendered dimensions of workplace violence and co-worker dynamics that differed from the accounts given by female participants, most notably in how they interpreted physical contact from residents and their relationships with casual co-workers; these accounts should be interpreted cautiously given the small number of male participants (n= 2).

If I'm getting punched in the face, that's abuse…a good thing about being a guy in this job is that we are physically bigger than a female.

— Jordan, HCA

Theme 3: Consequences of Work Stress on HCAs' Lives

This theme comprised three subthemes describing how work stress affected participants beyond the workplace: physical health consequences, emotional and psychological consequences, and spillover into personal and professional life.

It will bring me to tears at home…I was just furious, so stressed out…I was shaking, like it was the worst for me.

— Mary, HCA

I get nightmares. It is nightmares and not feeling well, and sometimes it's getting up at night.

— Lena, HCA

Several participants described how stress from work extended into their personal relationships and, in turn, affected their performance and focus at work, illustrating a bidirectional spillover between the two domains.

I'm really grumpy. Every little thing makes me explode on that day. I cannot be a normal person. I'm stressed. I'm running around.

— Lena, HCA

Theme 4: Navigating and Coping with Work Stress

This theme comprised five subthemes describing the range of strategies participants used to manage work-related stress, spanning adaptive and maladaptive approaches: social support and venting, self-care and "chill out" strategies, maladaptive coping behaviours, formal counselling and Employee Assistance Program (EAP) use, and gaps in stress-management training.

I talk about it to almost anyone that will listen…I process my stress by getting it out, by talking about it, getting other people's opinions.

— Mary, HCA

I'm very athletic, I do lots of exercise…when I'm at work, I'll kind of just take a deep breath and just kind of stand and relax and mellow out for a minute or two.

— Jordan, HCA

A smaller number of participants described coping behaviours with the potential for harm, including emotional eating, substance use, and absenteeism.

I'll emotionally eat, if I'm stressed…it just makes you feel gross. It affects the way I react.

— Linda, HCA

I've used medication, and I've used counseling for sure to help. I haven't accessed anything through work though…I've used my benefits for counseling; I paid for counseling myself.

— Kat, HCA

All 14 participants reported that they had never completed any workplace-based course or lecture specifically addressing work-related stress or stress management; five participants had received basic stress-management content during their initial HCA training program rather than at their place of employment. These findings are original results of the present study and are reported here without external citation.

I didn't receive any training in [facility] about stress…trust me, we were put in those situations.

— Iliana, HCA

Table 3. Themes and subthemes generated through reflexive thematic analysis

Theme	Subthemes
Understanding and experiencing work stress	Physical and emotional manifestations of stress
	ambivalence toward job satisfaction
Genesis of work stress	Resident- and family-related stressors
	leadership and organizational stressors
	co-worker relationships
	workload and staffing pressures
	gendered experiences of violence
Consequences of work stress on HCAs' lives	Physical health consequences
	emotional and psychological consequences
	personal/professional spillover
Navigating and coping with work stress	Social support and venting
	self-care strategies
	maladaptive coping
	formal counselling/EAP use
	stress-management training gaps

Discussion

This study explored how HCAs working in ALFs in Southern Alberta experience, interpret, and manage work-related stress. Consistent with the study aim, four interconnected themes emerged describing how stress is recognized, generated, experienced, and managed by this workforce.

Interpreted through the transactional model of stress and coping, participants' accounts in Theme 1 reflect an ongoing process of cognitive appraisal: physical sensations such as shoulder tension and rapid breathing (Sue) and emotional responses such as heightened anxiety (Mary) can be understood as markers of a primary appraisal that workplace demands exceeded available resources.[21 23 24] Viewed through the job demands-resources model, the organizational and relational stressors described in Theme 2: workload, staffing shortages, unsupportive leadership, and difficult co-worker relationships, function as job demands, while the coping strategies described in Theme 4, such as social support, self-care, and formal counselling, function as the job resources participants drew upon, or in several cases lacked access to, in response to those demands.[20-22] The consequences documented in Theme 3: physical, emotional, and interpersonal spillover, are consistent with the JD-R proposition that a sustained imbalance between demands and resources produces strain.[20-22]

These interpretations are grounded directly in participants' own words: Joe's account of working hard without recognition and Alayna's description of fear toward management both illustrate how a perceived absence of leadership-related job resources compounded the demands already present in day-to-day resident care.

While this study offers a detailed, ALF-specific account of HCA work stress, its findings should be understood as consistent with, rather than distinct from, the broader body of research on stress among direct-care workers; the contribution of this study lies primarily in its detailed, setting-specific description rather than in identifying an entirely novel phenomenon.

The relative emphasis on organizational and staffing-related stressors observed in this study is broadly consistent with prior Canadian research documenting rushed and missed care among HCAs in nursing homes, which similarly identified workload and staffing as central concerns.[10] By contrast, other research characterizing burnout more broadly across the nursing home HCA workforce has placed greater relative emphasis on emotional exhaustion and depersonalization as outcomes rather than on their organizational antecedents.[11] This contrast suggests that the relative salience of specific stressors versus their downstream emotional consequences may vary depending on study focus and setting, rather than reflecting a contradiction in the underlying phenomenon.

As the sole researcher who conducted the interviews, coded the data, and interpreted the findings, my own prior experience working as an HCA likely shaped both what participants chose to share and how their accounts were interpreted. This positionality was managed through ongoing reflexive journaling, member checking, and maintenance of an audit trail (described in Methods); nonetheless, the absence of an independent second coder or investigator triangulation remains an important limitation of this reflexive process and is addressed further below.

Coping strategies described by participants spanned a continuum from clearly adaptive (social support, exercise, formal counselling) to clearly maladaptive (substance use, absenteeism), with several strategies, such as "chilling out" through leisure activities, occupying a more ambiguous middle ground depending on frequency and context.

Table 4 summarizes this conceptual synthesis, linking job demands identified in Theme 2 to the appraisal processes described in Theme 1, the consequences described in Theme 3, and the coping resources described in Theme 4, within a single integrated model.

Table 4. Conceptual synthesis linking themes to the transactional model of stress and coping (TMSC) and job demands-resources (JD-R) model

JD-R job demands (Theme 2)	TMSC appraisal (Theme 1)	Consequences (Theme 3)	JD-R job resources / coping (Theme 4)
Workload, staffing shortages, resident/family behaviours, workplace violence, unsupportive leadership, co-worker conflict	Primary appraisal of demands as exceeding available resources; secondary appraisal of coping options	Physical symptoms; emotional/psychological strain; spillover into personal and professional life	Social support and venting; self-care and leisure; formal counselling/EAP; (absent or underused) stress-management training

Health care aides are not currently a regulated profession in Canada, and training requirements, certification standards, and job titles vary across provinces.[21 27] This regulatory and educational variability, documented elsewhere in the workforce literature, provides useful context for interpreting participants' repeated calls for standardized stress-management education, discussed further under Practical Implications below.

Participants described physical and emotional signs and symptoms of stress, including headaches, muscle aches, insomnia, anxiety, and depression, that are consistent with findings from previous research on occupational stress among health and direct-care workers.[12] Interestingly, despite these identified stressors, only 40% of participants expressed overall job dissatisfaction; this dissatisfaction was attributable primarily to organizational factors such as leadership style and

limited decision-making opportunities, workload, and lack of appreciation, while participants were generally satisfied with their wages, which they considered financially rewarding relative to comparable positions.

The behavioral and relational sources of stress identified by participants, including lack of appreciation, threat of violence, role conflict, and role ambiguity, align with previously documented sources of burnout among nursing home health care aides.[11]

The structural work-environment stressors identified in this study, workload, shift work, insufficient skills training, demanding work schedules, and the physical work environment, are similarly consistent with prior research on missed and rushed care among health care aides, which identified workload and staffing constraints as central determinants of care quality and staff strain.[10]

Workplace violence was identified as a significant, and in some cases gendered, source of stress in this study, with participants reporting physical, verbal, and sexual violence from residents. This finding aligns with a large systematic review and meta-analysis reporting that approximately 62% of healthcare workers globally experience some form of workplace violence from patients or visitors, with verbal violence the most common form.[28 29]

The physical and psychological consequences described by participants in Theme 3 are consistent with existing literature on the health effects of work stress in healthcare settings, which similarly documents musculoskeletal complaints, emotional exhaustion, and sleep disturbance among direct-care staff exposed to chronic occupational stress.[11 30]

These findings collectively point to organizational and structural factors as central, modifiable contributors to HCA work stress in the ALF setting, a point developed further in Practical Implications below.

Practical Implications

Recommendations in this section are limited to those directly supported by participants' accounts. Broader system-level policy proposals, such as national occupational regulation, are noted only briefly as directions for future consideration rather than as conclusions drawn from this study's findings.

Directly informed by participants' accounts of workload and staffing pressures (Theme 2), ALF administrators should consider evaluating staffing levels against resident acuity and reviewing scheduling practices where feasible within existing resource constraints.

Directly informed by participants' repeated description of an absence of workplace-based stress-management training (Theme 4), ALF administrators and educators should consider incorporating stress-recognition and coping-skills content into orientation and ongoing in-service education for HCAs.

Directly informed by participants' accounts of unapproachable leadership and limited recognition (Theme 2), facility leadership may benefit from regular, structured opportunities for two-way communication between HCAs and management, and from explicit recognition practices.

Directly informed by participants' accounts of resident- and family-related violence (Theme 2), facilities should ensure HCAs have access to de-escalation training and post-incident support such as debriefing or counselling.

This study has several important limitations. The analysis was conducted by a single researcher, without an independent second coder or investigator triangulation, which may have constrained the range of interpretations considered during coding and theme development. The sample was drawn from three facilities operated by a single organization in two Southern Alberta communities, limiting the transferability of findings to other regions, organizational contexts, or facility types. Participant self-selection may have introduced bias, as those who volunteered may have held more pronounced views about work stress than the broader HCA workforce. The sample included only two male participants, limiting the ability to draw firm conclusions about gendered experiences of stress and violence. The English-language inclusion criterion may have excluded HCAs whose experiences differ due to language or cultural background, and my own prior experience as an HCA, while supporting rapport and interpretive insight, may have subtly influenced both data collection and interpretation, as discussed above.

Conclusion

This study provides a detailed, ALF-specific account of how HCAs in Southern Alberta experience, generate, and manage work-related stress, describing four interconnected themes spanning stress recognition, its organizational and relational origins, its consequences, and the coping strategies used to manage it. The findings suggest that organizational and interpersonal factors, more than resident care tasks themselves, are the predominant sources of stress described by this workforce, and that current access to formal stress-management education and support is limited. These findings may usefully inform facility-level training and leadership practices; given the qualitative, single-organization design of this study, broader causal or system-level policy conclusions should be drawn with appropriate caution and tested in future, larger-scale research.

Recommendations for Future Research

Future research should extend the transactional model of stress and coping and the job demands-resources model to a larger and more geographically diverse population of HCAs, including those working in long-term care and hospital settings, and should aim to recruit a more gender-balanced sample. Quantitative and mixed-methods studies building on the themes identified here could help establish the relative prevalence and impact of specific stressors, including workplace violence, across the Canadian HCA workforce.

Author Contributions (CRediT)

Mohammed Al-Hassan: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Validation, Visualization, Writing – original draft, Writing – review & editing.

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Conflict of Interest

The author declares no conflict of interest.

Research Highlights

What is the current knowledge?

- Health care aides experience considerable occupational stress in assisted living facilities.
- Work-related stress negatively influences caregivers' physical and psychological well-being.
- Organizational and interpersonal factors contribute to workplace stress among frontline care providers.

What is new here?

- Four interconnected themes describe how health care aides perceive, experience, and manage work stress in the assisted living context.
- Organizational factors, workload, staffing shortages, leadership, and workplace relationships, emerged as primary sources of stress.
- Health care aides highlighted a need for standardized stress-management education, stronger organizational support, and improved workplace resources.

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